



# VineLine

Paratransit Services

Medical Professional Verification Form  
(Health Professional to Complete)

City of Lodi Transit  
221 West Pine Street  
Lodi, CA 95240  
(209) 333-6706

## AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize you to **release any information necessary to determine my eligibility** for VineLine ADA Paratransit service provided by the City of Lodi.

The City of Lodi has assured me that the requested information will be held in strictest confidence, and will be used only to determine my eligibility for paratransit service.

### Identification of Physician or Health Care Professional

(Please type or print clearly)

Name and Title of Professional \_\_\_\_\_

Address \_\_\_\_\_,  
(Number and Street) (City) (Zip Code)

Agency \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

### Applicant Information

Date of Birth \_\_\_\_\_ SSN # (Last four) \_\_\_\_\_

**Signature of Applicant** \_\_\_\_\_ **Date** \_\_\_\_\_

**Printed Name of Applicant** \_\_\_\_\_

## VineLine PROFESSIONAL VERIFICATION FORM

**This application may be completed by one of the following:**

- a rehabilitation specialist
- an occupational or physical therapist
- an independent living counselor
- social worker
- physician or registered nurse
- psychologist
- mental health counselor
- other health professional who is familiar not only with applicant's disability but also their ability or inability to travel on the public transit system

To process this application, VineLine needs information about the effects of the applicant's disability on his/her **functional capability** to ride the regular fixed route bus service. This information is necessary to determine whether he/she is eligible for paratransit service under the regulations of the Americans with Disabilities Act (ADA).

The information you provide in this form will aid the City of Lodi in making an ADA eligibility determination. For the benefit of the applicant, please answer the questions as fully and accurately as possible. All information will be kept confidential except as required by law.

The individual's condition must **prevent** travel on a GrapeLine fixed route, either all of the time, temporarily, or only under certain circumstances. Disability alone and distance to and from a bus stop do not, by themselves, qualify a person for paratransit service. Inconvenience or decreased comfort is not a basis for qualification.

**(Please type or print clearly. Do NOT use ICD-9 or DSM codes.)**

Applicant's Name \_\_\_\_\_

Capacity in which you know the applicant \_\_\_\_\_

Medical diagnosis \_\_\_\_\_

\_\_\_\_\_ Date of Onset \_\_\_\_\_

Prognosis \_\_\_\_\_

1. Does the applicant use any of the following aids for mobility?

(Check all that apply).

- |  |  |
|--|--|
| <input type="checkbox"/> Manual Wheelchair       | <input type="checkbox"/> Electric Wheelchair |
| <input type="checkbox"/> Power Scooter           | <input type="checkbox"/> Cane                |
| <input type="checkbox"/> Crutches                | <input type="checkbox"/> Walker              |
| <input type="checkbox"/> Personal Care Attendant | <input type="checkbox"/> Service Animal      |
| <input type="checkbox"/> <b>Other</b> _____      | <input type="checkbox"/> None                |

2. What category is the applicant's disability?

☐ **Visual**

☐ **Physical**

☐ **Mental Impairment**

3. Applicant's Height \_\_\_\_\_ Weight \_\_\_\_\_

4. Is the applicant's condition temporary? \_\_\_\_ Yes \_\_\_\_ No

If Yes, eligibility recommended until: \_\_\_\_/\_\_\_\_/\_\_\_\_

5. Can the applicant wait outside without assistance for 15 minutes?

☐ Yes

☐ No

6. How far can the applicant travel with or without a mobility aid?

☐ Less than 1 block

☐ Less than 3 blocks

☐ Less than 6 blocks

7. Can the applicant cross the street without assistance?

☐ Yes

☐ No

If No, why \_\_\_\_\_

8. Can the applicant comprehend written or spoken instructions?

☐ Yes

☐ No

9. Can the applicant recognize a destination or landmark?

☐ Yes

☐ No

**I hereby affirm under penalties of perjury that the statements made herein are true and correct.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Please print your name and title: \_\_\_\_\_

License #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Agency: \_\_\_\_\_

**PLEASE MAIL COMPLETED FORM TO:**

**City of Lodi Transit**

**Attention: ADA Coordinator**

**221 West Pine Street**

**Lodi, CA 95240**

**IF YOU HAVE QUESTIONS, PLEASE CALL 333-6706**